STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		155757	B. WING		07/12/2012
NAME OF E	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
				OSEGATE DR	
ROSEGA	ATE VILLAGE		INDIAN	IAPOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
10000					
	This visit was f	or Investigation of	F0000		
	Complaint IN00	_			
	Compium i vo	0111 <u>-0-</u> .			
	Complaint IN00	0111252 Unsubstantiated			
	due to lack of e				
	Unrelated defic	iencies cited			
	Survey dates:				
	July 11 & 12, 2	012			
	,				
	Facility Numbe	er: 011149			
	Provider Numb				
	AIM Number:	200829340			
	Survey Team:				
	Mary Jane G. F	ischer RN			
	Census Bed Ty	pe:			
	SNF: 38				
	SNF/NF: 107				
	Total: 145				
	Census Payor T	Sype:			
	Medicare: 36				
	Medicaid: 78				
	Other: 31				
	Total: 145				
	Sample: 4				
	Supplemental s	ample: 30			
	<u> </u>				
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 07/2	TE SURVEY TPLETED 12/2012		
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.						
	Quality review 7/18/12 by Suzanne Williams, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 99AS11

Facility ID: 011149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 07/12/2012		
		155757	B. WING			07/12/20	12
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			75	REET ADDRESS 510 ROSEGA IDIANAPOLIS			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	FIX (EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	(X5) OMPLETION DATE
F0282 SS=D	CARE PLAN The services provided facility must be propersons in according written plan of carried Based on observice facility record review, the the resident's platin that when a resident services provided facility and the services facility and the serv	AUALIFIED PERSONS/PER Avided or arranged by the rovided by qualified dance with each resident's re. ation, interview and re facility failed to ensure of care was followed, sident had a history of of care was developed,	F0282	best ca with th	cility strives to provide the are possible. In accordance nat policy we have addressed lowing issue.	0	8/06/2012
	plan of care in redevices for 1 of falls in a sample	failed to implement the egard to safety assistive 3 residents reviewed for of 4. [Resident's "B"]		strips p	Resident "B" had non-skid placed by the left side of the front of the recliner and in if the commode on 7/12/12 a.M.	t	
	on 07-11-12 at 1 included, but we cataracts, corona depression, diaboral hallucinations are delusions. These current at the time. The most recent dated 06-20-12 is a history of falls months, was incompliable to the coronal properties.	esident "B" was reviewed 1:50 a.m. Diagnoses re not limited to, ary artery disease, anxiety, etes, hypertension, ad senile dementia with e diagnoses remained ne of the record review. fall risk assessment, ndicated the resident had within the past three continent of bowel and paired vision, is confused, I a walker and had an		deficie for fall place. interve all env were ii 3) . (IDT) w proced Progra . for cus IDT, an 8/5/12 Develo regard	All residents have the fial to be effected by this nt practice. Residents at risk is have fall interventions in IDT reviewed all fall entions on 7/13/12 to ensure ironmental fall interventions in place. Facility Interdisciplinary Tear will review policies and dures on Fall Management of the management which es but is not limited to care	m	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 99AS11

Facility ID: 011149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
	155757		B. WING 07/12/2012			2012	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			OSEGATE DR		
POSEGA	ATE VILLAGE				APOLIS, IN 46237		
NOOLGA				INDIAN	AI OLIO, III 40231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					plan development and		
	The current plan	of care, originally dated			implementation of interventions.		
	11-22-11 indicat	ted the resident was at			· Director of Nursing Services		
	risk for fall due	to history of falls,			(DNS)/Designee will be notified of a		
		on, hallucination,			falls and inquire what the immediat	e	
	-	d forgets to use walker."			fall intervention was put into		
		•			effect. Nurses are responsible for		
		rventions to this plan of			the immediate intervention and		
		'bed alarm, call light			documentation of the intervention		
	within reach, a c	hair alarm, non skid			in the ASC Fall Event and temporary care plan.		
	footwear, the wa	ılker within reach, a			· All falls will be discussed by		
	scoop mattress,	and non skid strips to			the IDT the next business day and		
	_	liner and commode."			the weekend supervisor or manager		
					of the day will review all falls to		
	During observat	ion on 07-11-12 at 10:15			ensure implementations of		
	_				continued and new interventions.		
	· ·	t's room lacked the			· Fall risk assessments and ca	re	
		the non skid strips in			plans are completed upon admission	n	
	front of recliner	and in front of the			and no less than quarterly based on		
	commode.				the Resident Assessment Instrument	t	
					(RAI).		
	An additional in	tervention noted as "FYI			· Customer Care		
	[for your inform	ation] and dated			representatives/Nurse Manager on		
		resident's record included			Duty will be given copies of their		
	-	to the left side of the			customer care rooms fall care plans		
		to the left side of the			so they can ensure environmental		
	resident's bed."				interventions are in place during		
					rounds. New fall care plans will be		
	On 07-12-12 at 1	10:45 a.m., the Director			distributed weekly with care plan schedule and as needed.		
	of Nurses verifie	ed the strips in front of the			scriedule and as needed.		
	recliner and com	mode were not in place,			4)		
	and the additional "FYI" for strips to the				· The MDS		
		esident's bed also had not			Coordinator/Qualified Designee is		
	been implement				responsible for the completion of		
		cu.			the Fall Management CQI audit tool		
	2.1.25(-)(2)				weekly for four weeks, then		
	3.1-35(g)(2)				bi-monthly for two months, then		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155757			07/12/2012
			B. WING	ADDRESS CITY STATE ZID CORE	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
50050.	TE \ # 1 A OF			ROSEGATE DR	
ROSEGA	TE VILLAGE		INDIA	NAPOLIS, IN 46237	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				quarterly for two cycles and results	
				reported to the CQI committee ove	
				seen by the Executive Director if	
				threshold of 95% is not achieved	
				action plan will be developed to	
				ensure compliance.	
			I	1	ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 99AS11

Facility ID: 011149

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
155757			B. WIN	G		07/12/	2012
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=D	The facility must environment remains hazards as is possible receives adequated assistance devices. Based on observative record review, that the safety of a resident was idented a recent fall injury, the nursing the non-skid stript specific sections aid the resident's affected 1 of 2 resustained injury. [Resident "B"] Findings included The record for Ron on 07-11-12 at 1 included, but we cataracts, coronal depression, diable hallucinations and delusions. These current at the times the safety of the recent dated 06-20-12, and the recent dated 06-	RVISION/DEVICES ensure that the resident enins as free of accident esible; and each resident e supervision and es to prevent accidents. ation, interview and he facility failed to ensure sident in that when a ntified as a fall risk and with a significant head hig staff failed to ensure has had been placed in of the resident's room, to gait/balance. This esidents who fell and hin a sample of 4. Esident "B" was reviewed 1:50 a.m. Diagnoses	F03	23	F323 Our facility strives to provide the best care possible. In accordance with that policy we have addressed the following issue. 1) Resident "B" had non-skid strips placed by the left side of the bed, in front of the recliner and in front of the commode on 7/12/12 at 10:55A.M. 2) All residents have the potential to be effected by this deficient practice. Residents at risk for falls have fall interventions in place. IDT reviewed all fall interventions on 7/13/12 to ensure all environmental fall interventions were in place. 3) Facility Interdisciplinary Team (IDT) will review policies and procedures on Fall Management Program. An in-service with post test for customer care representatives, IDT, and nurses was completed by 8/5/12 by ED/DNS/Staff Development Coordinator/Designeer regarding Fall Management which includes but is not limited to care	n	08/06/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 99AS11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET			ETED	
155757		B. WING 07/12/2012			2012		
			B. ((11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	months, was inc	ontinent of bowel and			plan development and		
	bladder, had imp	paired vision, was			implementation of interventions.		
	confused, disorie	ented, used a walker and			· Director of Nursing Services		
	had an impaired	gait/balance.			(DNS)/Designee will be notified of a		
	_				falls and inquire what the immediat fall intervention was put into effect.		
	The current plan	of care, originally dated			Nurses are responsible for the		
	_	ted the resident was at			immediate intervention and		
		to history of falls,			documentation of the intervention		
		· ·			in the ASC Fall Event and temporary		
	1	on, hallucination,			care plan.		
		d forgets to use walker."			· All falls will be discussed by		
		rventions to this plan of			the IDT the next business day and		
	care included a '	bed alarm, call light			the weekend supervisor or manage	r	
	within reach, a c	hair alarm, non skid			of the day will review all falls to		
	footwear, the wa	ılker within reach, a			ensure implementations of		
	scoop mattress, a	and non skid strips to			continued and new interventions.		
		liner and commode."			Fall risk assessments and car		
					plans are completed upon admission		
	During the initia	l tour of the facility on			and no less than quarterly based on the Resident Assessment Instrument		
		a.m., with Licensed			(RAI).	L	
					· Customer Care		
		#5 in attendance, the			representatives/Nurse Manager on		
		ntified by the nurse as			Duty will be given copies of their		
	_	fall." The Licensed			customer care rooms fall care plans		
		the resident "fell last			so they can ensure environmental		
	night or really th	is morning at 5:25 a.m.			interventions are in place during		
	while [resident]	was walking. There is a			rounds. New fall care plans will be		
	raised bump on t	the back of the right side			distributed weekly with care plan		
	of the head, and	[resident] has had an			schedule and as needed.		
		d pressure since the fall."			4)		
		-			4) The MDS		
	During observat	ion on 07-11-12 at 10:30			Coordinator/Qualified Designee is		
		esident was seated in a			responsible for the completion of		
		ensed Nurse moved the			the Fall Management CQI audit tool		
					weekly for four weeks, then		
		vay from the raised area.			bi-monthly for two months, then		
	I he head had a l	arge hematoma on the	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 07/12 /	ETED	
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			•	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	posterior right up resident's head a color. Review of the fa 07-12-12 at 8:55 Director of Nurs the resident was room lying on "F socks on and paj <sic> appeared to room, walker was [range of motion raised area to back Responds to name [name of individe about fall and vir Nursing staff is to closely for any copressure] and to During observational a.m., the resident interventions of front of recliner commode. An additional interpretation of the commode of the commode. An additional interpretation of the commode.</sic>	cility "Event Report," on a.m. and provided by the es, indicated on 07-11-12 "found on the floor in R" [right] side, non skid ama gown. Nursing o be headed to the rest is next to bed. ROM all +, pupils reactive, has ek of head on right side. The and touch, Spoke with ual at physician's office tals, no new orders. To monitor resident hanges in BP [blood the raised area." It is no no 07-11-12 at 10:15 the non skid strips in and in front of the the revention noted as "FYI"		IAU	quarterly for two cycles and results reported to the CQI committee over seen by the Executive Director if threshold of 95% is not achieved action plan will be developed to ensure compliance.		DATE

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Event ID: 99AS11

Facility ID: 011149

If continuation sheet

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	OF CORRECTION IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/12/2012			
	PROVIDER OR SUPPLIER ATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
	of Nurses verified the strips in front of recliner and commode were not in place, and the additional "FYI" for strips to the left side of the resident's bed also had not been implemented.						
	The facility "Fall Management Program," provided by the Director of Nurses on 07-11-12 at 2:30 p.m. indicated the following:						
	"POLICY [bold type] It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to falls."						
	"PROCEDURE - Fall Risk. A fall risk assessment will be completed upon admission, re-admission, quarterly, annually and with a significant change in condition."						
	"Post Fall - 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and provide necessary treatment. 2. If the resident experienced an injury from the fall, contact facility DNS [Director of Nursing Services] / ED [Executive Director] per facility protocol. 3. The						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757 A. BUILDING B. WING			COMPLETED 07/12/2012			
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIENG REGULATORY OR family will be no of all falls. 4. A	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) otified by the charge nurse fall event will be as the resident has been		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	be completed in possible root cau	ed for. The report must full in order to identify uses of the fall and ate interventions [bold					
	3.1-45(a)(2)						

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Event ID: 99AS11

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